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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the First Amended Accusation Against:<br><br>David Richard Jensen, M.D.<br>619 W Avenue Q<br>Suite B<br>Palmdale, CA 93551<br><br>Physician's and Surgeon's Certificate No. G44704,<br><br>Respondent. | Case No. 800-2014-010471<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 8, 1981, the Medical Board issued Physician's and Surgeon's Certificate Number G44704 to David Richard Jensen, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2019, unless renewed.

## JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

6. Respondent David Richard Jensen, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of four patients. The circumstances are as follows:

Factual Allegations Regarding Patients #1-3

A. Patient 1 saw Respondent from May 2012 to May 2015. The CURES report showed 68 prescriptions for Norco, Xanax, Tramadol, and Codeine syrup. This amounts to approximately 120 pills every 21 days, or 6.9 pills a day.

B. The records show she was seeing Respondent for anxiety, insomnia, and chronic back pain. There does not appear to have been any efforts to use other methods to control the pain or a referral to a pain management specialist.

C. Patient 2 was a regular patient of Respondent. Her daughter complained that patient 2 abused Xanax and Vicodin. Patient 2 would finish a 30-day supply of pills within two weeks. Although the patient's husband called Respondent, he continued to prescribe.

D. She was treated for a variety of conditions including migraines, insomnia, menopausal syndrome, chronic low back pain.

E. The CURES reports showed prescriptions from May 2012 thru May 2015. There were 106 prescriptions for Xanax, Vicodin, Phentermine, Zolpidem, Valium and Restoril. This

amounts to a continuous pattern of opiates and benzodiazepines at a rate of 120 pills a month, or 4 pills a day. She was not referred to a pain management specialist or mental health specialist.

F. Patient 3 had severe fibromyalgia which affected her brain. She had a variety of other ailments including attention deficit disorder (ADD) and post traumatic stress disorder (PTSD) and was afraid to leave her home. She was also treated for migraines, bipolar disorder, and chronic low back pain. She took Depakote and Xanax for anxiety and Norco and Percocet for pain. She was "allergic" to electricity and gets "electrocuted" when she used a phone.

G. The CURES report revealed 162 prescriptions from May 2012 to May 2015. She was prescribed Xanax, Restoril, Vicodin, Clonazepam, Percocet, and other drugs. This pattern amounted to approximately 7.3 pills a day. There was no referral to a pain management specialist or mental health specialist.

Allegations of Gross Negligence

H. There was no documentation of an effort to wean the patients off opiates.

I. There was no evidence of using other methods to treat their pain.

J. There was no documentation of a referral to pain management or mental health specialists.

Factual Allegations regarding Patient 4

K. Patient 4 saw Respondent when she was diagnosed with breast cancer. The patient's daughter complained that her mother was overprescribed painkillers, which caused her to become addicted and contributed to her diagnosis of cirrhosis. The family asked Respondent's office to stop prescribing, but he refused.

L. Patient 4 had jaundice and a swollen abdomen which were symptoms of cirrhosis but Respondent never referred her to a liver specialist.

M. A review of the CURES report revealed a pattern of prescribing opiates and benzodiazepines. There were 64 prescriptions over a 3-year period of Vicodin, Oxycodone, Xanax, and Clonazepam. It approximated 4.5 opiate pills a day.

Allegations of Gross Negligence:

N. Respondent prescribed a dangerous number of opiate pills to this patient.

O. The co-administration of benzodiazepines in some months was unsafe.

P. There was no referral to a pain management specialist.

Q. Respondent did not use alternative methods to treat pain.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

7. Respondent is subject to disciplinary action under code section 2234, subdivision (c), in that he was negligent in his care and treatment of six patients. The circumstances are as follows:

A. The facts and circumstances as alleged in paragraph 6, A-M, are incorporated here as if fully set forth herein.

Factual Allegations Regarding Patient 5:

B. The Medical Board received a complaint from the patient's family detailing that they asked Respondent on numerous occasions to stop prescribing to Patient 5 because she was an addict. Respondent continued to prescribe to the patient after her husband suddenly passed away. On January 6, 2017, Respondent contacted Patient 5 and tried to convince her into not releasing her medical records as he was in fear it would harm him.

C. The records show that Patient 5 saw Respondent from January 2012 through the end of 2016, however his records were illegible so Respondent transcribed them. He transcribed visits from January 2015 to 2016, and for some reason, he did not transcribe visits on October 12, 2015, November 9, 2015, December 7, 2015, and January 7, 2016.

D. On January 8, 2015, Patient 5 was seen for chronic lower back pain and anxiety. She was prescribed Norco, Soma, Ativan and Tramadol. CURES showed that this regimen of medications basically remained the same through 2017.

E. There are several comments in Respondent's transcribed notes that do not appear in the original handwritten notes. On March 3, 2016, Respondent notes that when the pharmacy called to request the prescription for Lorazepam, he denied the refill. In his

transcribed notes he writes that he denied refill requests for Tramadol on April 19, 2016, Ativan on May 5, 2016, Soma on May 24, 2016, and Tramadol on May 26, 2016, but these comments do not appear in his handwritten notes.

F. This patient was on the same medication regimen from at least 2012, but there was nothing in the record to indicate if they were working.

Allegations of Negligence:

G. Respondent failed to do urine toxicology screens.

H. Respondent failed to document the family's concerns about his prescribing.

I. Respondent failed to attempt to minimize dosage.

J. Respondent failed to meaningfully address the patient's anxiety diagnosis.

K. Respondent failed to refer Patient 5 for physical therapy and pain medicine in a timely manner.

Factual Allegations Regarding Patient 6:

L. Patient 6 died from a "morphine effect" and the death was listed as an accident.

M. Respondent had been treating the patient for years for liver cancer, Diabetes and obesity. The patient was being prescribed Morphine, Hydrocodone, Lisinopril, Furosemide and Terazosine.

N. There were about 37 visits to Respondent from January 7, 2011, to October 30, 2013. Initially, Respondent noted the patient had "metastatic carcinoma of liver." Subsequently he was diagnosed with hypertension, Hepatitis C, and metastatic tumor in the liver. He was treated with Percocet, which is used to treat severe to moderate pain.

O. The tumor was felt to be the source of the chronic pain.

P. The CURES report for this patient starts in January 2010 and ends in October 2013. While a few other physicians prescribed to Patient 6 at that time, most of the prescriptions are from Respondent. For approximately the first 9 months, the patient received Norco (used to treat pain but has a high risk for abuse and dependence) of

180 pills per month, which is equivalent to 60 mg morphine daily, a dose concerning for higher mortality.[1]

Q. In August 2011, Patient 6 was prescribed MS Contin (contains Morphine) in addition to the Percocet. In March 2012, the MS Contin was increased to 60 mg. In September 2012, his pain regimen was Morphine Sulfate 60 mg and Morphine Sulfate 30 mg per day. Morphine is an opiate used to treat pain and is addictive and prone to abuse.

R. On October 14, 2010, Respondent switched to Endocet (relieves moderate to severe pain) which was 90 mg morphine equivalents daily.

S. On August 29, 2011, he began to receive Morphine sulfate 30 mg on a monthly basis, in addition to the Endocet. At this rate, he was taking 165 Morphine milligram equivalents per day.

T. On June 28, 2012, he began receiving Morphine sulfate 60 mg #60 monthly, together with Vicodin. At this rate he was taking 180 Morphine milligrams equivalents a day.

U. On October 19, 2012, he began receiving an additional dose of Morphine sulfate 30 mg monthly, increasing his Morphine milligrams equivalents to 210 per day.

V. On July 29, 2013, the patient was receiving Morphine sulfate 60 mg 90 monthly, in addition to the 180 pills of Vicodin. This increased his Morphine equivalents to 240 milligrams per day.

Allegations of Negligence:

W. Patient 6 was on a crescendo course of opiate administration from Respondent over time. The patient's morphine equivalent dosing quadrupled over four years' time.

X. Respondent failed to do urine toxicology screens.

Y. Respondent failed to document a social history.

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[1] The Centers for Disease Control and Prevention (CDC) use this Morphine milligram equivalent (MME) equation. Patients prescribed higher opioid dosages are at higher risk of overdose death. Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, or other measures to reduce risk of overdose.

Z. Respondent failed to score the patient's pain and assess his prognosis.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G44704, issued to David Richard Jensen, M.D.;

2. Revoking, suspending or denying approval of David Richard Jensen, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering David Richard Jensen, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 18, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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